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In A NutShell

A Publication of the **MENTAL PATIENTS' ASSOCIATION**

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A Précis of some relevant points from Dr. David Cohen's "A Critique of the Use of Neuroleptic Drugs in Psychiatry" (Chapter 5 of "From Placebo to Panacea: Putting Psychiatric Drugs to the Test", edited by Seymour Fisher and Roger P. Greenberg, New York: Wiley, 1997) with substantiating quotes commentary, and references.

— compiled by Byron Fraser (16/11/98)

Dr. David Cohen has been studying psychiatric drugs as a clinician and researcher for the last 16 years and is a professor at the University of Montreal. To contact Dr. Cohen write him at:

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1) On the top of p. 178 Dr. Cohen states that "...no biological dimension specific to schizophrenia has yet been charted." This echoes his comments in a recent (Winter '97/'98 issue) interview in **Dendron** magazine, page 34, where he said:
"...no specific, no biological dimension — whether it be biochemical, neurological, structural, anatomical, electro-physiological — no biological dimension specific to 'schizophrenia' has yet been charted. You may have heard or seen or read a number of contrary affirmations. The fact is, we do not know the cause or the causes of 'schizophrenia'. If we did know, if we had found them, it would be a Nobel Prize immediately and schizophrenia would be considered officially a neurological disease and would be in neurological textbooks. This has not happened yet."

Renowned psychiatrist, Dr. Thomas Szasz, said virtually the same thing when he spoke to an audience of about 500 people at our Temple Shalom here in Vancouver last year — viz.: "If we ever discover that 'schizophrenia' is a "disease of the brain", we already have a medical specialty for dealing with this — it's called neurology". By way of substantiation, in a recent article ("Diagnosis in the Therapeutic State", **Liberty** magazine, Sept. 1994) he wrote: "The fact that not a single textbook of pathology recognizes depression and schizophrenia as diseases has not in the least dampened popular and political enthusiasm for their diagnosis and treatment" and followed this up by citing four of the top current textbooks on pathology (see his note 10).

Additionally, here are some quotes from Section 1 of Dr. Ty C. Colbert's **"Broken Brains or Wounded Hearts: What Causes Mental Illness"** (1996) wherein he summarizes the current state-of-the-debate in the scientific literature about the "medical model":
"...the truth is that researchers have never discovered a single defective gene or accurately identified any chemical imbalance that has caused an emotional disorder; nor have they ever proven that brain abnormalities are responsible for **even one** emotional disorder."

— p. 2

(Continued on page over)

"Ken Barney, a psychiatrist writing in **The Journal of Mind and Behavior** (Vol 15, No.1, 1994, p. 22), states, 'The idea that 'schizophrenia' is a hidden disease entity, with a soon-to-be-discovered biogenetic 'cause' has been thoroughly debunked.' "

—p. 3

"...the psychiatric community itself openly admits that no real biological cause for these disorders has ever been proven."

—p. 17

"To date, however, not one proven biological cause for mental illness has been found. Even though biological psychiatry assumes a physiological cause for all major emotional disorders, there is still no proven cause-and-effect relationship between any specific disorder and any specific physical defect."

—p. 29

"...neuroleptics have no specific therapeutic effect on people diagnosed as schizophrenic because schizophrenia is not a brain disease."

—p. 41

"Twin studies can be misused in attempts to substantiate the medical model. The simple truth is that these studies, when correctly analyzed, firmly support an **environmental** model, not a genetic model."

—p. 63

"...there is absolutely no scientific evidence that the so-called psychiatric disorders of schizophrenia, depression, mania, ADD, obsessive/compulsive disorders, sociopathic behaviour, or any others are inherited."

—p. 84

"Psychiatric medication does not correct a chemical imbalance; it works to disable the emotional-cognitive aspects of the human mind."

—p. 97

"In their massive 20-page journal article titled 'Schizophrenia — A Brain Disease?' Chua and McKenna not only summarize all the brain imaging studies, but also give us a great summary of the biological model. In their opening paragraph in reference to schizophrenia, they state: 'There has been no identification of any underlying causal pathology.' (**British Journal of Psychiatry**, Vol 166, 1995, p. 563)."

—p. 98

2) At the top of page 183 we have the quote from Denber (1959): "The ability to induce an extrapyramidal action is a **sine qua non** of therapeutic effectiveness" which seems to continue to be the case despite the much-hyped claims for newer, so-called "atypical" neuroleptics such as clozapine and risperidone. As Dr. Cohen writes in "Neuroleptic Drug Treatment of Schizophrenia: The State of the Confusion" (**The Journal of Mind and Behavior**, Vol. 15, Nos. 1&2, 1994, page 152): "...despite frequent, unequivocal statements by renowned psychopharmacologists in the most prestigious psychiatric and medical journals to the effect that clozapine, a novel antipsychotic, is 'remarkably free' of typical EPS, easily available evidence suggests that this is simply a false claim." Similarly, in the aforementioned **Dendron** interview (p. 35) he states: "Risperidone, for example, within two years of its introduction, has been definitely linked with all extrapyramidal symptoms, including **tardive dyskinesia** and **neuroleptic malignant syndrome** (which can be fatal)." And further, "The control of behaviour or agitation is always obtained at a price. There cannot be a drug that will calm a person down quickly and

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not have some kind of toxicity. As a concept, it's impossible. It would be an illusion to think that you could obtain rapid, quick control of agitated behaviour with no other effect."

3) "However, after more than 40 years of research and clinical experience with NLPs, NLP dosages are not well mapped nor are patient's drug responses predictable. Furthermore, although NLP use is associated with several **dose-dependent** toxic effects, the minimum effective dosages of various NLPs are unknown." (Top of p. 186 — see also quote at top of p. 189).

4) Of the 9-month placebo study cited on pp. 190-191, Dr. Cohen says "...the results are still astonishing: Ward life remained completely unchanged and no one saw through the trick. Instances of patient misbehaviour were neither less nor more common than before the placebo substitution... After nine months, the authors tallied their results: 22 patients (56.5%) rated as definitely improved (including 11 discharged), 15 (38.5%) rated as unchanged, two (5%) rated as worsened." This certainly confirms my intuitions, gained from a good deal of institutional experience, that the wide-spread belief that mental patients would freak out, cause chaos, and run amok and/or be more violent off of medications is a totally fraudulent myth. My experience of being locked up with even the most supposedly violence-prone and dangerous criminally insane is that, while neuroleptic drug use does seem to cause some blunting of emotions and lethargy and cognitive dysfunction (dementia), etc., it does not seem to have any significant effect on stopping people from "acting out" violently or irrationally. That is to say: if they are going to fight, they are going to fight, and most even quite large NLP drug dosages have virtually nothing to do with stopping this. But the truth also is, of course, that most "mental patients" (at least in forensic settings) are virtually indistinguishable from any random selection of the average population with respect to propensity for irrational and/or violent behaviour on a day-to-day basis. Then, too, my experience of having taken neuroleptic drugs also is that they very often have **exactly the reverse effect** of calming agitation. As Dr. Cohen says (p. 33, **Dendron** interview): "What we hear about the drugs is they're really wonderful for agitated persons, the psychotic person, people in the throes of 'psychosis' — who are losing control, aggressive, wasting their money — and that early intervention with the drugs really does make a difference. Research does not show this to be accurate." In fact, " The second very common effect is exactly the opposite of that (**Parkinsonism**). It is called **akathisia**, which is psychomotor agitation (see also subsection on "Akathisia", pp. 206-207). The person will rock back and forth, shift from foot to foot; they will be fidgety, will pace back and forth, and will report agitation sometimes originating in their abdomen. They will be moving a lot and will look agitated. According to studies, akathisia affects up to three-quarters of the patients. Some of the latest neuroleptics, risperidone for example, are noted for effects like that. Akathisias very often are seen as psychotic agitation. It's very difficult to distinguish a drug-induced effect from the original psychiatric disorder. Very often akathisia calls for increasing doses and then a vicious cycle continues." This precisely confirms my own first-hand experience and the implication that neuroleptic drugs are contraindicated even for short-term "crisis intervention" purposes seems justified. Furthermore, "Several studies show up to two-thirds of people not responding, even in the very short term, that is even in the two weeks curing the acute crisis. The short term is where drugs have been thought to really have their major impact in the immediate control of psychomotor agitation. This kind of effect is not shown to be as fantastic as it is often claimed to be. So, in the short term we have some problems."

5) Under the subsection "Effectiveness Studies", Dr. Cohen notes that: "There is no uniform way to define relapse: It may be operationalized as a return to active medication, rehospitalization (if patients

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are living in the community), an exacerbation of symptoms that would qualify as an active episode of schizophrenia, a set increase (sometimes over a set period) in psychotic symptoms as measured by a known rating scale, and so on." So it is probably important to understand that there exists this fairly high degree of ambivalence and relative variability as to just what actually constitutes "relapse". Much the same applies to whether or not the outcome "stabilization" on medications actually refers to any sort of optimal recovery, "cure", or even improvement, of course, as Dr. Cohen demonstrates further along.

6) This said, we do see that what the scientific literature seems to show (p. 192) is that "...for only one in three patients on NLPs who do not relapse during a set study period, NLP treatment appears to be the determining factor." This finding correlates nicely with the research cited in the C.M.H.A. 's recent position paper on "Community Committal: Another View" where it is shown that "Non-compliance with medication and other medical factors were involved in 31% of cases (of relapse)" (Kent & Yellowlees, 1994). Interestingly, the average number of people who will go off their medication at any given time when released to the community is approximately 30% (Torrey & Kaplan, 1995) so there would seem to be an invariant 1-to-1 relationship vis-a-vis the likelihood of relapse whether one stays on or goes off of medication which is identically proportional with the number of people who actually do or don't. That is to say, fully 70% of those who are relapsing are on medications and, as the C.M.H.A. paper also shows "...medical factors are not as predominate as social factors in leading to rehospitalization." The obvious implication of this research is that both judicial and clinical coercion "aiming to ensure strict compliance with NLP treatment to decrease risk of relapse...may be missing the point entirely for large subgroups of patients." (bottom of p. 193). In the same vein, with respect to predicting future dangerousness of mentally disordered offenders — **even if relapse due to non-compliance with medication were a significant factor** — here is a relevant excerpt from lawyer Carla McKague's 1990 paper for the CMHA's National Conference on Mental Health, "The Charter, Psychiatry, and the Criminal Code":

"The second myth is that there is a higher rate of violence among people who have been diagnosed as mentally disordered than there is among the general public, and that therefore mentally disordered offenders present a greater risk to the public than do other offenders. In fact, study after study has confirmed that the incidence of violence in this group is no higher than in the general population, and some studies have found it to be substantially lower.

...But the fact remains that the vast majority of people with mental disorders are non-violent, and present no risk to themselves or others.

A third, and related myth is that psychiatrists can predict with some accuracy what the chances are that a particular individual will engage in violent behaviour. The fact, demonstrated over and over again, is that they cannot. They are no more accurate in making these predictions than are lawyers, homemakers or accountants, and are wrong much more often than they are right. In fact, in the well-known **Tarasoff** case in California, the American Psychiatric Association submitted an **amicus curiae** ("friend of the court") brief which includes the following passage:

The Court's formulation of the duty to warn fundamentally misconceives the skills of the psychotherapist in its assumption that mental health professionals are in some way more qualified than the general public to predict future violent behaviour of their patients. Unfortunately study after study has shown that this fond hope of the capability to predict accurately is simply not fulfilled.

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Branches Over the Wall

Personal Empowerment through Creativity

by Dennis Strashok

When it comes to the question of consumer empowerment and whether or not it is really working in our society at the present time, I find that I have a unique and, I hope, exciting perspective on the whole matter. Many times in the past, people within the mental health community had suggested to me that I would make a good advocate or that I had the possibility of being productive in an advocacy capacity. Yet, in my lifestyle and vocation, I felt that advocacy was not my particular calling and that, instead, there were other facets of my life, less directly related to my diagnosis of schizophrenia, that were important to me and that could lead to worthwhile vocation and endeavor. It was these other facets that I eventually pursued and I have found both individuals and organizations along the way that have helped to empower me to be both a more productive mental health consumer and a more worthwhile individual in general.

About fifteen years ago I had read a very interesting little book by Elizabeth O'Connor entitled "Eighth Day of Creation". This book, written from a Christian spiritual perspective, spoke of the gifts that we all have and of entering into a gift-evoking community. I found it very inspiring and, although I had not written much poetry for years (ever since my University days), I began to write in earnest. I found that my poems inspired melody lines and rythmic forms within me and, with some knowledge of music, I began to write songs, my poems evolving into short, personal folk melodies that spoke of the human condition. During a stay in a Mental Patient's Association group home, I had much freedom to explore and work on the song forms that were slowly birthing within my heart and mind. This was a very productive phase of my songwriting and poetry writing career.

It seemed to me that my illness had just been a springboard or a prepartion for using my gifts and talents to speak out about many matters - hope, love, madness, and spirituality being some of the topics I explored in my writing. Along the way, I took some training in Desktop Publishing on the Macintosh computer and became involved in publishing the MPA newsletter "In A Nutshell". Gradually my life was beginning to take a shape and form that revolved around the exercise of gifts, talents and abilities that, a few years before, I had not even known I possessed. I felt greatly empowered to be able to be a voice, not only of those who are mentally ill, but of all those who seek the truth and seek authentic lifestyles in the midst of today's chaotic and fragmented society. Jim Gifford, then editor of the "In A Nutshell" was very helpful to me and has been a strong guiding force in this creative revolution, himself being a poet and a writer.

A few years later I became involved in an organization which has been of great benefit to me. Primal Mental Health Productions Association helped me put together a tape of some of my songs, entitled "Possibilities". And , although I was little shy about pushing myself into the limelight, I performed at Coffee Houses and found the experience rewarding and satisfying. Tessa Warburton and Bob Turner were instrumental in helping me to use my backlog of material in this way. Most recently I have been leading a Writer's Workshop with Primal every Wednesday night and everyone involved agrees that the workshop is a rich and rewarding experience. Primal's mandate is to integrate consumer artists in music, writing, and the visual arts with mainstream artists who do not necessarily have a background with mental illness. It works very well in practice.

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Minute Particulars

by Andrew Feldmar

In August, 1985, on the BBC Radio 4 programme, **In the Psychiatrist's Chair**, Dr. Anthony Clare was interviewing R.D. Laing. Clare, a psychiatrist from Dublin, was also a broadcaster, and he invited the philosopher of madness, R.D. Laing, to the studio. Laing talked openly about his sever depressive swings and his heavy drinking. He thought it would do him a lot of good to start writing on these two topics. He expressed his fear of being overtaken by "real, Scottish, involutional melancholia". "What would you want someone like me to do if you became profoundly depressed?" asked Clare. "Make sure that I hadn't anything rational to worry about in terms of duties, obligations, commitments, etc., to free me of a sense of guilt, worthlessness and failure. Transport my body to a home. If you had any drugs that you thought would get me into a brighter state of mind, I'd be grateful for them.", was Laing's reply.

A very depressed patient of mine who hardly ever speaks to me explained the other day that he wants to kill himself before the demons who torture him constantly take over his mind, rendering him irrational and cut off from reality. He wrote out a quote from a novel he's been reading and handed it to me. It says, "that was what I wanted: to be taken over by something so that no one could expect me to produce a thing. A condition that made a product, a production, any productivity unimaginable. Even to myself". I was struck by how similar this request is to Laing"s. They both ask for a guilt-free asylum where one can stop without shame, without pressure to perform. In **Angel in Armor**, Ernest Becker wrote, "The Demonic is real. It is engendered by the failure of men to act. It comes into being when men fail to act individually and wilfully, on the basis of their own personal, responsible powers". My patient lost his person, his individuality. He told me all he ever was, seemed to him to be **roles**. He played 'son', 'accountant', 'husband', 'father', but he had forgotten, if he ever knew, who HE was. No one seemed to care either as long as he performed his roles satisfactorily. Now he didn't want to have to play 'patient'. His only hope remained that through suicide he could re-connect with the source of his true being, the source of his aliveness, his long-lost spirit.

One of Laing's teachers was E. Graham Howe, who published **The Triumphant Spirit** in 1943. The book is a study of depression and although it has long been forgotten, I have read nothing more illuminating to date. Howe knew that to be depressed is to feel condemned, the guilty culprit of some unknown crime. The patient insists that God does not love him anymore. When matter counts for more than spirit, mechanization eats and destroys the individual. If I am 'mechanized' I must have a boss, I must be driven, I have to cut off from my living spirit. If, instead, I could live in an 'organized', organic fashion, I could remain obedient to my spirit within. The problem of healing depression is how to regain inspiration and how to reinstate the spirit in its true supremacy. Depression is a paroxysmal attack associated with deficiency of vitality, inhibition at the highest level and more or less complete paralysis of the will. Howe lists six major symptoms: (1) **Self-centredness**, one cannot enter into anything nor give anything out; (2) **Retardation**, or

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UnderDog
The Persecution of God
by Jim Gifford

Anger, abuse, ignorance, ridicule, rejection, fear– 'the slings and arrows of outrageous misfortune'– corrupting through dysfunctional socialization, and scarring 'Original Face' Nirvanic Consciousness of Infinite Love, our birthright as Children of God, the godhead at the Centre of Our Being.

In their early years, many are indoctrinated with the negativity of guilt about the past and apprehension for the future. Parents often hold a baby in their arms, consoling it with soft words of 'here now, here now' but, as childhood progresses, they are straightjacketed in restrictions and taboos amid the dual polarity of the three-dimensional world.

Unilateral commands such as 'no', 'don't', and 'can't' are imprinted on the brain, the finite organ of Infinite Mind, which is belittled into finitude, causing the delusion of Intelligence Quotients, labelling Children of the Cosmos as imbecile, idiot, moron, normal, genius. Buckminster Fuller, one of the greatest thinkers of the Twentieth Century, when asked if he was a genius, said no, he just didn't have borders, boundaries, or divisions in his head. He had reawakened to Original Enlightenment, our true nature when we enter this plane of existence, spirits of Spirit, blessed with the opportunity for human experience.

Unfortunately, in the School of Life we inherit mankind's past genetic/ collective archetypal karma of the illusory duality of Good and Evil, the Original Sin of Duality. When we 'make ends meet', we are focused at the Centre of Being, the Tree of Knowledge undergoing metamorphosis, transforming into the Almighty Tree of Life, existent in the Silence prior to The Word of the White Holistic Big Bang, its roots and winglike branches The Source of The Universe.

As Above, So Below. In each person, The Tree of Life is the electric-energetic coiled serpentine force flowing upward from the chakra of libido energy to the Crown of Being, emitting the Realization You Are God; God In You; You In God. Messianic ChristForce is Enlightened Mind, Spirit in this world but not of it.

Original Enlightenment is lost in the passage of time in this world. To again achieve this Ultimate State, as Tibetan Buddhist Founder Milarepa's last words reveal, you must put calluses on your butt, intimating sitting meditation, metaphorically meaning hard work. Having struggled with the shadow demons of unrealized human potential, archetypal transcendance means being Christ Itself, The Second Coming, the resurrection of our birthright. This experience may be extreme and severe with an overwhelming sense of omnipotence and omniscience, in our secular and material-mad culture, the individual subjected to institutionalization in mental asylums, debilitated, demoralized and dehumanized, wearing The Crown of Thorns, verily The Persecution of God.

Thus, the mental patient reacts with symptoms of struggle, revolt, rage, and sometimes violence. For many of these souls, it leads to a lifetime of pain, suffering and anguish – for, as Soldiers of The Divine – they are psychically slaughtered by an insane world. Yet, 'no pain, no gain'. You only grow in difficult and challenging periods.

Some breakthrough again

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Things Never Add Up

by Sam Roddan

In my day, the White Lunch at 321 Hastings, just above Columbia, was the hungry man's favourite hang out. It was a large roomy place with marble table tops, comfortable chairs and a good view of the scenery.

The meals were cheap, hot and served up rough but ready. Bacon and eggs with toast cost 30 cents. Pancakes, usually buckwheat and straight from the griddle, were 5 for 35 cents. Coffee was a specialty. A big mug cost a dime which included a second. The mugs were heavy stone ware, held the heat and kept a man's hands warm for a good read of Liberty or the News Herald. At the back of the White Lunch was the washroom. Before a chap hit the road for the day, he might be able to work on his ablutions and pick up a quick shave provided that had a razor and the blade.

Most of the customers tried to keep a regular schedule each day. The Relief Offices on Hamilton were usually first on the list then over to The Church of the Open Door at Gore for advice and a pair of dry socks. Next came the lanes behind the Empress Theatre and the cafes along Pender to check out the garbage cans and read up on the menus in the windows. At the posh Ho Ho, (for a pocket full of cash which nobody ever had) you could get such dainties as shrimp balls with abalone, tong gow stuffed with shredded shark fin, barbecued pork wrapped and steamed in lotus leaves. Of course, twice a week you could get bread pudding minus the raisins over at Central City Mission. And this was "on the house".

At night along the lanes behind Dunlevy and Heatley, a chap could pick up little "care packages" on the fence rails. Old timers called them "bird feeders". By early morning the packages would be gone. Mrs. Macdonald, who lived on Dunlevy preferred to call them "emergency rations". She said she always tried to make them personal and not have a man feel beholden.

"He can take or leave it for someone in greater need," she said."But in the moonlight it's very sad to see a man up on his tip-toes reaching for his rations and then dodging back into the darkness."

In this world we never know what's coming up next. Or what's up or who's keeping score. Or when will prosperity make it around the corner at Main and Hastings... But miracles do happen and tragedies too.

In September, 1939, all the homeless and hungry suddenly disappeared off Hastings. The White Lunch was half empty. Line ups at the Relief Office began to dwindle. Like magic most of the homeless and hungry now had a warm bed, blankets, heavy work boots, stockings, underwear and three squares a day. Everything was on the house and they even got $1.30 a day, and that was just for starters and did not include free trips to England, Europe and/or Italy.

Memory can often be very unforgiving. Only the other night I was thinking of a sign on the door of the Bethel Home Mission on Cordova. It read: Man Does Not Live By Bread Alone... Strange and wondrous how some words stick with us like a burr, a nettle, a thorn, a slap in the face. And yes, a gentle reminder.

BookWorm

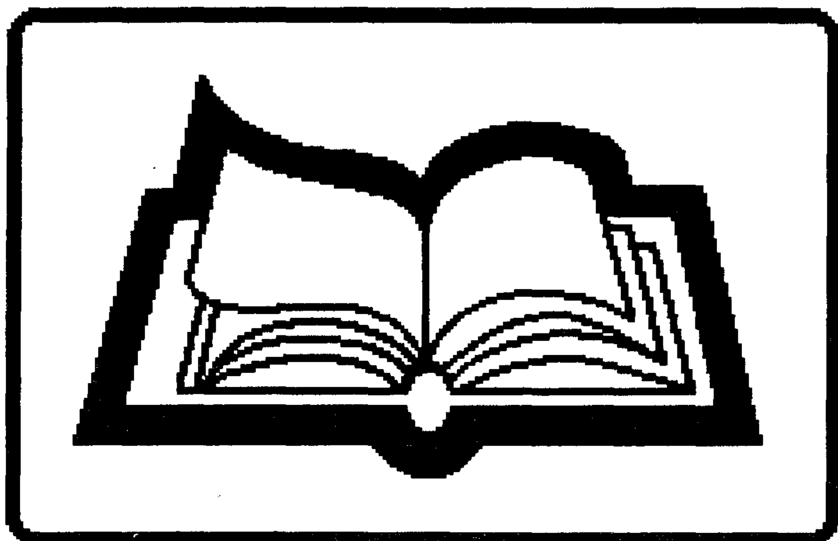
The Healing Connection

by J.B.Miller & I.P.Stiver
Beacon Press, 1997
Reviewed by Andrew Feldmar

This book was written by two veterans of the Stone Center, Wellesley College, Massachusetts: Jean Baker Miller, M.D., a professor of psychiatry, and Irene Pierce Stiver, Ph.D., a psychologist. It represents over 20 years of thinking about women doing therapy with women. But whether you're a man or woman, reading this book feels like a breath of fresh air. I found nothing that wouldn't be true for me or other men; the authors, though feminists, go beyond gender to the pain and suffering of persons.

In the last chapter they write: "Equal in importance to clinical training and academic preparation for therapy is an understanding of the larger relational context in which therapy occurs. Our relational view leads us to a new perspective, a different concept about therapy's connection to the larger world. In our view, both patient and therapist have developed within a culture that has deprived us all of fully growth-fostering relationships, but they are coming together to try to create something different, something that runs counter to the damaging effects of the larger society. Both patient and therapist are engaged in a creative act of healing and empowerment."

In 1964, 33 years prior to the above, R.D. Laing wrote: "Psychotherapists are specialists in human relations. But the Dreadful has already happened. It has happened to us all. The therapists, too, are in a world in which the inner is already split from the outer...The psychotherapeutic relationship is therefore a re-search. A search, constantly reasserted and reconstituted, for what we have all lost and whose loss some can perhaps endure a little more easily than others, as some people can stand lack of oxygen better than others, and **this re-search is validated by the shared experience of experience regained in and through the therapeutic relationship in the here and now**....Psychotherapy must remain an **obstinate attempt of two people to recover the wholeness of being human through the relationship between them.**" It saddens me that the same truths get articulated over 30 years apart, only to be forgotten again. Theory and practice have developed in complex ways. And yet, for a few who care, it is impossible, in the words of Pasternak, "not to fall ultimately, as into a heresy, into unheard of simplicity." Laing called it, the healing factor, Co-Presence. Being together without altering the other to suit one's own script, without dread, hatred, denial, projection, idealization, without the denigration of the otherness of other. Miller and Stiver call it "connection". They mean by it an interaction that is mutually empathic and mutually empowering. "Disconnection" is defined as "the psychological experience of rupture that occurs



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Public Transit

by Reinhart

The moon may be cold, the sun may be hot;
Some say it's hell waitin' at the bus stop.
It may be early, it may be late;
I may see you there at half past eight.
Sometimes I'm first, sometimes I'm last;
One day the freaker drove right past.
I get on, I get off, I don't have a car;
I know bloody well I won't get too far.
It makes no difference, it's always the same;
Check them out and you'll find them totally lame.
You get on first, you sit at the back;
You watch them board all along the track.
In ones and twos they climb aboard,
The tired, the beaten, the whole hung-up horde.
They each grab a seat that's intended for two;
Alone there they sit with nothing to do.
Freakin' unreal, every single seat
Occupied by a solitary resentful piece of meat.
None wants to share, meet or talk;
If they weren't lazy to boot they'd probably walk.
Fellowship's gone, comraderie never came;
The whole human race is driven insane.
They don't like each other, they're afraid and uptight,
And each arrogant bastard thinks he's right.
Every stranger's a pervert, killer or creep;
That's how they think but they don't say a peep.
God forbid that you meet a girl,
On a busload of prisoners in their own crazy world.
Well it's gettin' interestin', no more single spots;
Watch them pick and choose, like drawing lots.
The women sit with the women, safer I guess;
The men do the same, afraid to confess.
Then there's the spaces that remain to the end,
That the dirty, the ugly, fat or mean might defend.
The bus fills up, they're standing in the aisle;
Clones going nowhere, too disgusted to smile.

Public Transit
(continued)

The vehicle is full, they're in there tight;
None makes contact, they can't find the light.
They still don't talk, they got nothing to say;
Who the hell wants to know you anyway.
Of course there's exceptions, some get on together;
They'll ignore everyone else and stick to their tether.
A Chinese pair may be yakking away;
Chinese of course, Chinese they'll stay.
Or Hindus speaking their own secret tongue;
No intruders wanted, that's how it's done.
Mostly it's just the ringin' of the bell
That sends them comin' and goin' to hell.
It happens like this, every freakin' day;
Not an ounce of love lost along the way.
Stare at the signs, stare at the floor;
Stare into space, 'til you're out the door.
Don't expect to make friends, don't expect romance;
You haven't got a goddamn chance.
The people are wounded, scarred, in pain;
Imaginations are at stake, they must remain sane.
They're elevator aliens, guilty and scared;
Every last one wants to be spared.
They reject each other, they must,
Else they couldn't go on; they'd bust.
Trapped in their skulls, none of them free;
In a bondage that denies them humanity.
Freaks in chains of their own designs;
Spreading contagion along the lines.
Paying the fare, riding the bus;
How do you stop them from becoming us.

Branches Over the Wall

(Continued from page 5)

From these experiences, I have found that the key to personal empowerment within the mental health scene has as much to do with the "personal" as with the empowerment. Too often, we think in stereotypes, even when it comes to empowerment and I believe that a vital key is allowing ourselves to function as whole people, not denying the process that we have been through, but making the most of the opportunities presented by having a different view of life than the average person. Every one of us is an individual, with his or her own strengths and weaknesses, as well as gifts and talents. We must recognize the rich and varied tapestry of humanity that exists within the mental health community and allow the potentials of each individual to come to the fore in an expression of unique viewpoint and voice. When we recognize that empowerment has not only to do with government bureaucracies, organizations, and lawmakers but also to do with finding acceptable, authentic roles for ourselves that do not negate our past, but reveal some of the depth of experience that can be portrayed and communicated, then we will truly be empowered to come out of ourselves and live within the broader community.

Finally, let me say, to those of you who are seeking empowerment in your own lives: do not forget the creative side of your personalities. You have a rich experience to draw from and the things you can say in the creative arts will reach out and touch the lives of many people. So, go for it!

Minute Particulars

(Continued from page 6)

fixation, for nothing flows, one lives in petrified eternity, or in constant frozen fear; (3) **Guilt**, for the depressed cannot bear to sin, he was fearfully and obsessionally good; the illness of depression is especially the lot that falls on so many 'good' people; (4) **Worthlessness**, because one feels hopeless, empty, nothing; (5) **Insomnia**, like depression itself, needs to be treated by **rest**, with great patience on all sides; in spite of constant pleas that something must be done, the kindest condition for this insufferable complaint is that it should be suffered willingly; (6) **Suicide**, like all symptoms, has a protective, healing purpose: it seeks to cure by finding the source again, so that the body's dead-weight may be cast off and the healing presence of the spirit may be rediscovered.

'I AM' is a spiritual statement of our responsibility to manifest out a particular quantum of the spirit within the resistant medium of our earthly lives. It is always wrong to COPY or to PRETEND, yet the pressures to do so are great. To free ourselves from the depressing compulsion to be GOOD, we need the strength and courage to seek TRUTH.

UnderDog

(Continued from page 7)

after initial birth and rebirth, thriving in the Give and Take of Unconditional and Infinite Love, after having been Awash in the Baptism of Godly Tears. They "see through the dark veil, clearly", the illusory world of the Magic Show to which the vast majority are attached and enchanted, Maya flowing through one universal stream of consciousness, the Perfect Dream of God, stars: neurons of God's Mind; We, Ideas. Amid the tragedy of the world, they are joyous, dwelling in a Void Dance of Cosmic Atoms.

In the upward/downward spiraling, spinning process of creative evolution, "The Ten Thousand Things" are perfect in nature, and getting better. You know, in your Heart and Soul, the Greatest Lesson you will ever learn: to Love and be Loved in return. And, at long last, after endless lifetimes, you again enter The Paradisiacal Garden of Eden.

BookWorm

(Continued from page 9)

whenever a child or adult is prevented from participating in a mutually empathic and mutually empowering interaction". They recognize that **the** "most terrifying feeling that a person can experience is psychological isolation. This is not the same as being alone. It is feeling that one is locked out of the possibility of human connection and of being powerless to change the situation. In the extreme, psychological isolation can lead to a sense of hopelessness and desperation. People will do almost anything to escape this combination of **condemned isolation and powerlessness.**" Including suicide. Laing put it this way: "whether life is worth living depends for me on whether there is love in life". Different vocabulary, same message. When there is a connection between people, there is more energy, more action, more knowledge, more sense of worth, and more sense of participation.

Miller and Stiver are not sentimental. "Empathy does not mean 'being nice'", they write, "it means trying to be with the truth of another person's experience in all its many facets". It's a popular notion in the West that becoming a self-sufficient individual is the goal of human development. For Miller and Stiver, "the goal is not for the individual to grow out of relationships, but to grow into them". The job of the therapist then is to be authentically present and participating in the therapy **relationship**.

This is a book that could save lives, both patients' and therapists', and yet I fear it will be marginalized, forgotten and unheard. In 33 years, I hope that someone will re-discover the same fundamental truth. Why is it so difficult for our species to hold onto it?

The Mysterious

The most beautiful thing we can experience is the mysterious. It is the source of all true art and science.

Albert Einstein

(Continued from page 4)

The brief then cites an A.P.A. task force report which stated:

Neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or "dangerousness". Neither has any special psychiatric "expertise" in this area been established.

The brief admitted that in predicting long-term dangerousness, psychiatrists were wrong sixty percent of the time — worse than chance. More recent studies have shown that they are little, if any, better at predicting short-term dangerousness. The result of this inability to predict is natural; in order to minimize risk, psychiatrists grossly over-predict violence. In perhaps the most striking example I know of, a court decision resulted in the release of 967 residents of a maximum security psychiatric hospital. One-third returned to the community and two-thirds went to ordinary psychiatric hospitals. In the next four and one-half years, only 26 engaged in violent behaviour — a misprediction rate of 97%."

7) As Dr. Cohen also elucidates on page 192, the usual criteria for treatment effectiveness have excluded outcomes in the social and vocational spheres which may be far more meaningful measures in terms of actual recovery or "cure" than any sort of drug-induced "stabilization". He says: "Symptoms and rehospitalization are relatively easy to measure, but do not reveal how patients really fare overall and over time, in social and vocational spheres. With the advent of 'care in the community', researchers have had to broaden outcome measures to include social functioning and quality of life". And, although, as of 1992, there apparently were "...no studies that demonstrate the outcome of neuroleptic treatment in schizophrenia using all these criteria", we know that NLPs " have no direct positive effect on social functioning (Diamond, 1985) or a distinctly negative effect. Dr. Cohen writes "...NLP doses (and medication regimen) typically used in the 1980's exerted a negative impact on social integration... In all likelihood, this negative impact results from NLP's tendency to produce or accentuate social withdrawal or negative symptoms and to interfere with learning and with the ability to apply skills learned during the medicated state to non-medicated states". This finding directly mirrors my own personal experience and interpersonal experience with numerous people taking neuroleptic drugs in institutions and in the broader community. As Dr. Cohen says, "psychic indifference" is the first predominant effect of neuroleptics and this translates on a daily behaviour level as constant lethargy interspersed with stimulant addictions (tobacco and coffee, etc.) together with the desire to "sleep all the time", social withdrawal, and a gradual descent into tardive dementia. I have witnessed the latter especially in many formerly high-functioning patients (including professors and other PhDs!). As Dr. Ty C. Colbert says in this context:

" Obviously there are thousands of individuals whose emotional condition has been stabilized with the help of medication. We now know, however, that these drugs do not stabilize or cure a mental or emotional 'disease', but actually stabilize a person's emotional life by disabling it, often permanently".

Or, additionally:

"...simply attempting to reduce symptoms can actually lead to more emotional woundedness".

— p. 25 (same as above)

As well, Dr. Cohen demonstrates in his section on "Neuroleptic-Induced Extrapyramidal Symptoms (EPS)" that "they add significantly to any pre-existing emotional-mental problems..."

8) Discussing the meta-analysis of 368 schizophrenia outcome studies from 1895 to 1992 by Hegarty et. al. (1994), Dr. Cohen notes (p. 194) significantly that "...improvement declined after the 1970's, reaching the rate of 36% in the 20 NLP outcome studies published since 1986, 'a level that is

statistically indistinguishable from that found in the first half of the century'." More colloquially, in his recent **Dendron** interview, he described these findings as follows:

"There is a study that came out in the November 1994 issue of the **American Journal of Psychiatry**. It's called a "meta-analysis", which means that they took every single outcome study in schizophrenia of this century, from 1895 until 1992, and looked at the impact of different treatments. Now, over the century of this meta-analysis covered a lot of different things. It covered: dousing them with water, fever, such as giving them malaria, convulsive treatments - shock treatments, insulin comas. It covered psychotherapy and it covered neuroleptics from the 1950s onward. The meta-analysis compared the outcome of something like 386 different studies and found that the improvement rate from the last twenty studies of this century — from 1986 to 1992, all using neuroleptic drugs — was 36%. Then they compared that with the studies from the first two decades of the century: 1985 until 1925. And they found that the improvement rate was 36%. It was identical. This gives you a perspective of over a century.

We have not necessarily come very far in the actual treatments we're applying. The drugs are not really working like we've said they're working. They are not working as well as the treatments were 80 years ago."

In light of this information, the obvious question which arises is: If neuroleptic drug treatment has no better success or "improvement" rate than virtually any other historical non-drug treatment method, and yet we know that it has resulted in iatrogenic (physician caused) brain disease (TD, etc.) to the tune of at least several millions in the U.S. alone (see Dr. Peter Breggin's **"Psychiatric Drugs: Hazards to the Brain"**, 1983) — that, in short, "It is no exaggeration to call tardive dyskinesia a widespread epidemic and possibly the worst medically induced catastrophe in history" (Breggin in "Brain Damage, Dementia, and Persistent Cognitive Dysfunction Associated With Neuroleptic Drugs: Evidence, Etiology, Implications", **The Journal of Mind and Behavior**, Vol, 11, Nos 3 and 4, p. 429, 1990) — then why are we still using them? A corollary of this, of course, especially when we factor in a long-run relapse rate for deinstitutionalized neuroleptic-treated patients (see the **Dendron** interview, p. 33) of fully two-thirds, is to ask quite sensibly: How can the legal/psychiatric/political community justify increased legislative coercion to enable more forced drugging when:
A) This is obviously not "curing" or "stabilizing" anyone long-term better than any other traditional method, and B) It would appear from all the scientific literature that all drugging has ever done is treat symptoms temporarily while leaving underlying functional psychological disorders and/or attendant "problems of living", which resulted in institutionalization in the first place, essentially untouched.

9) Again we see (bottom of page 194) that in studies comparing placebo or non-NLP sedatives versus NLPs "the same overall degree of improvement was observed during treatment..." Why are we knowingly harming so many people then?

10) Under his "'Nonresponse' to Neuroleptic Treatment" subsection, Dr. Cohen notes that "Meltzer (1992)...estimates that up to 45% of patients do not respond to NLPs or develop such severe drug-induced behavioural toxicity that treatment cannot be continued after a few weeks" and states that another study (Collins, Hogan, and Awad — 1992) rated 50% of schizophrenics hospitalized for 6 months or more as non-responders. Once again, when we consider this non-result in something like half of the neuroleptic drug-taking population, together with the estimate of the 1980 APA **"Task Force Report: Tardive Dyskinesia"** that prevalence (of TD) may exceed 50% in older and long-term patients, we are moved to agree with Dr. Cohen that "...it is reasonable to entertain the suggestion that any other

(Continued page over)

(Continued from previous page)

field of applied scientific endeavor, results such as these would indicate that the field is in crisis, that conventional assumptions are wrong, and that major, paradigmatic change is absolutely necessary." (quoted in "Neuroleptic Drug Treatment of Schizophrenia: The State of the Confusion", **The Journal of Mind and Behavior**, Vol. 15, Nos. 1&2, p.152, 1994).

11) Once more, with respect to relapse rates vis-a-vis whether or not one stays on medication or not — which is all important to Review Board dispositions re on-going coercion and whatnot —, while granting that short-term abrupt withdrawal results in greater relapses, Dr. Cohen summarizes the overall scientific findings as follows: "Here are the implications: **Gradual NLP withdrawal is associated with the same relapse rate as continued NLP treatment.**" (p. 198)

12) A related study by Liberman et. al. (1994) gives more empirical data showing positive results with NLP withdrawal (p. 199).

13) Karon's review of psychosocial alternatives to neuroleptic treatment, "Psychotherapy vs. medication for schizophrenia: empirical comparisons" (in Greenberg and Fisher, 1989) found that: "most studies reviewed showed psychotherapy to be at least as effective as NLPs." Along the same lines, in his **Dendron** interview, Dr. Cohen stated that "I believe that psychosocial interventions in structured settings get the same and slightly better results than drugs" and he mentioned the Soteria studies which document the successful treatment of schizophrenia with low or no dosages of NLPs (see also pp. 200-201). "Patients receiving no medication demonstrated significantly better clinical results."

14) By way of confirming my comments in Point 7 above, Dr. Cohen says (p. 202): "The most widely acknowledged... effects of NLPs are lethargy and negative symptoms they induce in patients." And, with respect to the latter, not only are "Acute manifestations of EPS... occasionally reported present in 90% of NLP treated patients (Casey, 1989, 1991)", but there is now also an extensive literature on tardive psychosis and tardive dementia (see pp. 209-210). So it would seem to be more than appropriate for there to be a radical rethinking of "the commonly held notion that the advantages of NLP treatment outweigh its drawbacks." Key to the forcefulness of such a critique, Dr. Cohen points out (pp. 203-204), is debunking the "reification" of the distinction between supposedly "therapeutic" and "adverse" effects by clinicians and researchers operating, as he says, "...in a zeitgeist of psychotropic drug bias." What everyone must come to realize is that the pertinent question to ask is whether or not neuroleptics produce distinct desired effects (antipsychotic) **in addition** to distinct undesired effects (adverse) or whether they produce a **global neurological syndrome**. And if, as the scientific evidence seems to indicate, "...short-term response to NLPs will suggest that this often does not produce an abatement of psychosis. And in the long run, this outstanding NLP effect (temporary 'tranquilizing and subduing action' — B.F.) probably does little to help persons diagnosed with schizophrenia remain stable enough to be rated as 'improved' — whereas it is amply sufficient to produce disabling toxicity" (p. 213), then the conclusion which seems to force itself upon us is that we are dealing conceptually with an existential **singularity** of a predominantly negative (in terms of ostensible stated objectives) sort.

Further, we should note for the record the main erroneous premise based on faulty backward reasoning which underlies the whole assumption that neuroleptics are treating some extant biological disease entity in the first place. Illustrative of this is Dr. Cohen's answer (**Dendron** interview) to the following query:

"Q: There is an assumption that there is a cause right? There is an assumption that there is an underlying biological cause?

A: Most of that assumption comes from our investigations of the effect of drugs. When we look at the drugs, we see what the drugs do. For example, we see that they block dopamine reception, so the main biochemical hypothesis of 'schizophrenia' is called the **dopamine hypothesis.** We say 'Well, look we gave the drugs, the person is less agitated, and there is less dopamine transmission. So possibly why they were agitated is too much dopamine'. That's called the dopamine hypothesis." Similarly, speaking of John Wesley's use of electricity as a therapy in 1756 (in **"Broken Brains or Wounded Hearts"**, p. 276), Dr. Colbert offers this cogent insight: "...but he made the same mistake that has been made throughout the history of psychiatry. The faulty reasoning goes, 'If the treatment has an effect on the symptoms, the treatment must be related to the causes, or is directly affecting the cause'." Finally, related to this point, here is Thomas Szasz in "Diagnosis in the Therapeutic State": "... if the government validates a drug — by bestowing on it FDA approval for the treatment of, say, X — then, **ipso facto**, X is accepted as a disease (clinical depression, panic attack, schizophrenia). After all, if there is a drug to treat 'it', 'it' must be a disease."

15) Again, with respect to prevalence, we should note that "...since the first reported cases, the prevalence of TD has grown significantly" with an overall average rate of 24% in 1992 and anywhere from 90,000 to 625,000 patients contracting irreversible TD in any given year in the U.S. (pp. 207-208).

16) Under the subheading "Professional Resistance To Preventing Neuroleptic Iatrogenesis" Dr. Cohen points out that there exists no real informed consent to neuroleptic drug-taking or about known risks — a point he already made emphatically 7 years ago in his classic essay (with Michael McCubbin), "The Political Economy of Tardive Dyskinesia: Asymmetries in Power and Responsibility" (**The Journal of Mind and Behavior**, Vol. 11, Nos. 3&4, 1990), wherein he stated (p. 483):

"Informed consent remains at the heart of ethical medical practice. In our view, consent, not the presence of illness, constitute the only morally justifiable basis for medical treatment...

For a condition as severe as TD, a signed consent form should be a minimum requirement... Failure to abide by the conditions of consent forms would constitute, in absence of mitigating circumstances, sufficient grounds for courts to find malpractice."

17) Finally, "... A probable response to this line of argument is that, despite obvious drawbacks, NLPs remain the most effective of all available alternatives in preventing relapse in schizophrenia. However, existing data on the effectiveness of psychotherapy or intensive interpersonal treatment in structured residential settings contradicts this... when social and interpersonal functioning are included as important outcome variables, the limitations of NLPs become even more evident and the systematic implementation and evaluation of nondrug treatment alternatives even more pressing." (p. 213)

Some Websites of Special Interest For Consumers/Survivors

All preceded by www

.breggin.com
.efn.org/~dendron
.yukon.net/sos
.geocities.com/
.connix.com/~narpa
.power2u.org
.madnation.org
.antipsychiatry.org
.walnet.org.llf
.sussex.ac.uk/users/ssfd0/parker.html
.m-power.org
.well.com/user/achoo
.psychee.com
.ziplink.net/users/dystonia/arcindx.html

Great Expectations
by Terry Levesque

I have traversed many a mile. From bittersweet love affairs, to the rugged working individual. From the thoughtful student days, to the quiet solitude of a lonely room. Much belongs to the past. I look back twenty-five years and more. It amazes me that I have come through so much hardship and strife. And yet I carry on.

All the people I used to know have all gone their separate ways. Those that are still living are no longer part of my life. I am left with only a memory of the people and places that used to be. Friendships have been severed and lost over time. Relatives have passed away. Gone, too, is the easy laughter and the friendly smile. I am now much more aware of other people that do not know me and who do not share the same values. Time passes, yet in many respects, time has treated me well.

I still have my hopes and dreams but I now have few illusions. I tend to see life as it is and not as one would wish it to be. For the most part, I live in the present, although I can hardly stop myself from looking forward to the coming days. The coming of the next century is an awesome thing. It is part of my present reality. I see it as a new beginning, a fresh new start. Perhaps I am wrong. Only time will tell.

And as I live from day to day, I think and reflect and see. I think therefore I am. I do not dwell on the past, but neither am I lost in the unknown future. To be alive in the here and now is the important thing. To know that each day that passes is precious. And to be able to live for this moment in time.

This moment in time will quickly pass and the present will move forward. I am always aware of my reality and of being in the real world. I do not believe in fantasy or escapism. Mentally, I am prepared to meet the new day with open eyes. There will be many changes in the coming days. I am prepared to accept new things as a matter of course and to accept change as it happens. This is only to say that life still holds something in store and still holds a fascination.

Old friends have gone. The past is but a memory. Time passes and the present moves forward. I am living in this moment yet time has treated me well. Changes will come as we move into an unknown future. I meet the new day with open eyes. Everything is in order and I am living in harmony with the changing times. There may be great expectations - we will wait and see.

Laughs with Lewry

The psychiatrist said to the patient, "You have to give up smoking. You must give up smoking. I insist. No more smoking!"

The patient said, "Is it that bad for me?"

"No, but you're burning holes in my couch!"

Bulletin Board

kickstART 2001: A Synopsis

by

Patricia Duncon, L.P.N., B. SP. ED.
Mental Health Consumer-Advocate

CONCEPT: ***A ground-breaking, week-long forum and festival; designed to showcase original creations by artists and performers with DISABILITIES, working in theater, music, film, dance, visual and literary arts---to promote and strengthen an artistic and cultural identity among Canadians with disabilities.***

We will usher in the millennium by bringing together Canadian and International artists, to meet and learn from each other, in **a unique forum structured to foster an interchange of ideas and energy**. The arts and culture community and the general public will be invited to participate **as barriers break and boundaries blur - with extraordinary results!!!!**

Organizational Support: The festival will be operated as the inaugural event of the **Society for Disability Arts and Culture**, a not-for-profit organization registered in British Columbia, with a Board of Directors and an Advisory Board.

Location: **Vancouver**, British Columbia - **Canada's most accessible city**. It is the only Canadian city that has both a large number of accessible hotel rooms, in a range of prices **and** an accessible transportation infrastructure. Vancouver is also known as "Festival City", with 18 professional and 25 community festivals - *who have offered to share their expertise.*

Model Program: A week-long Forum and Festival in Spring, 2001 in Vancouver. Canadian and international artists with disabilities will gather for workshops, classes and master-classes, panel discussions and debates, ***collaboration*** and ***performance*** or ***exhibit***. The finale weekend to feature headline performances and exhibitions of group work created in workshops.

If you are interested in supporting *kickstART*: we need your help!!! Even if you cannot come to our organizing meetings, you can help with anything from a letter of support to donations of equipment, office space, volunteer time, expertise, money, etc. **Contact us!!!**

Telephone (message): (604) 714-1318
Email: kickstart2001@hotmail.com

* * * * * * * * * * * * * * *

*Also: **Theater Terrific Spring Series*** (1999) for Details and Brochure ***Phone: 222-4020***

Bulletin Board

Alternative Healing

Health Action Natural Society supports natural healing methods for mental illness. Ph 1-888-432-4267. Their local address is #202-5262 Rumble St., Burnaby B.C.

Vancouver Women's Health Collective has peer counselling and makes referrals to support services, groups, and does advocacy work in health care reform. Their address is 219 - 1675 W. 8th Ave., Vancouver, V6J 1V2. Info by phoning (604) 736 -5262

Freedom of Choice in Health Care, B.C. Chapter can be reached by phoning (604) 685-7835

Tzu-Chi Institute for Complimentary and Alternative Medicine is at 715 W. 12th Ave., Vancouver, They do research; have a clinic, resource centre, and library . They can be reached by phoning (604) 875-4767.

Vancouver/Richmond Mental Health Network sponsors many self-help groups including a Women's circle. Their address is #109 - 96 E. Broadway, Vancouver, V5T 4N9 and the Director of the Network, Helen Turbott may be reached at 733-5570.

The Gaia Garden Herbal Apothecary at 2672 W. Broadway, Vancouver, V6K 2G3, can help with transition therapy for people with psychiatric problems going from orthodox medication to herbs. Their phone number is 734-4372.

Freebies:

For those in need: Free clothing; Dishes
Choose from a variety of donations
At Community Resource Centre, 1731 W. 4th Ave., Monday to Friday, 9 am to 9 pm on request.

M.P.A. could use some help in the cost of
producing and publishing the 'In A NutShell' newsletter.
If you wish to help please mail this slip with appropriate funds to:

Mental Patients' Association
#202 -1675 W. 4th Ave.
Vancouver, B.C.
V6J 1L8

My name and address is:
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Include your full mailing address for a tax receipt for charitable donations.